

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-5-05.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e) it's a defense for the carrier if they timely comply with the IRO decision.

Two units per visit of therapeutic exercises from 8-27-04 through 9-24-04 **were found** to be medically necessary. More than two units per visit of therapeutic exercises, the manual therapy technique and ultrasound from 8-27-04 through 9-24-04, **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-27-05, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 95833 for 3-16-04 and 9-20-04 was denied as "G"-Unbundling. Per rule 133.304 (c) and 134.202(a)(4) carrier didn't specify which service this was global to. **Recommend reimbursement of \$81.82 (\$40.91 MAR x 2 DOS).**

CPT code 95851 for 3-16-04, 8-27-04 (2 units) and 9-15-04 was denied as "G"-Unbundling. Per rule 133.304 (c) and 134.202(a)(4) carrier didn't specify which service this was global to. **Recommend reimbursement of \$92.60 (\$23.15 MAR x 4 units).**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 3-16-04 through 9-24-04 in this dispute.

This Decision and Order is hereby issued this 9<sup>th</sup> day of March 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da  
Enclosure: IRO decision

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February 14, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT:  
EMPLOYEE:  
POLICY: M5-05-1322-01  
CLIENT TRACKING NUMBER: M5-05-1322-01/5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

**Records Received:**

Records Received from the State:

Notification of IRO assignment dated 2/2/05, 1 page

Letter from TWCC dated 2/2/05, 1 page

Medical dispute resolution request/response form, date stamp for receipt from requestor 1/5/05, 5 pages

TWCC-62 explanation of benefits for dates of service 3/16/04 through 10/4/04, 10 pages

Texas Compass claim/claimant summary dated 1/5/05, 1 page

Records from Requestor:

Operative report dated 6/23/04, 2 pages

MD prescriptions dated 3/10/04 and 8/14/04, 2 pages

Letter from Alpine Healthcare LLP dated 1/3/05, 2 pages

US Postal Services delivery confirmation receipt dated 11/5/04, 1 page

Medical dispute resolution request/response form, undated, 5 pages

Letter from Permian Claim Service, Inc dated 11/30/04, 1 page

TWCC-62 explanation of benefits for dates of service 3/16/04 through 10/4/04, 27 pages

Request for reconsideration statement dated 11/4/04, 1 page

Health insurance claim forms 3/16/04 through 10/1/04, 21 pages

Clinical SOAP notes dated 3/16/04 through 10/1/04, 77 pages

Office notes dated 3/16/04 through 9/20/04, 5 pages

Isometric muscle testing exams dated 3/16/04 and 9/20/04, 8 pages total

Computerized spinal range of motion exam dated 3/16/04 through 9/15/04, 8 pages total

**Treatment Summary/Case History:**

The patient is a 56-year-old male road construction worker who, on \_\_\_, was walking across a lowboy floor with one of the boards broken. He stepped on the board with his left foot, breaking it and the piece came up and struck his head, and then caused him to fall onto the floor injuring his left head, ear, neck and arm.

**Questions for Review:**

The dates of service in question are 3/16/04 through 10/1/04. Items in dispute: therapeutic exercises (#97110), manual therapy techniques (#97140), and ultrasound (#97035). Denied by carrier for medical necessity with "U" codes. Please address medical necessity.

**Explanation of Findings:**

I mostly agree with the carrier's decision, as follows:

A maximum of two units per visit of postoperative therapeutic exercises (#97110) from 8/27/04 through 9/24/04 are certified as medically necessary.

All remaining services and procedures – including all units of therapeutic exercises in excess of two units per date of service – are not certified as medically necessary.

Rationale: The daily "S.O.A.P." notes submitted for review in this case were clearly computer-generated, and in general, most computerized documentation – regardless of the software used – fails to provide individualized information necessary for reimbursement. The Centers for Medicare and Medicaid Services (CMS) has stated, "Documentation should detail the specific elements of the chiropractic service for this particular patient on this day of service. It should be clear from the documentation why the service was necessary that day. Services supported by repetitive entries lacking encounter specific information will be denied." In this case, there was insufficient documentation to support the medical necessity for the manual therapy techniques (#97140) and the ultrasound treatments (#97035) in question, since the computer-generated daily progress notes were essentially identical for each date of service.

However, the medical records submitted from the neurosurgeon adequately documented that a compensable injury had occurred, in fact, one that eventually required a 2 level cervical fusion. Based solely on this fact, along with written authorization to perform "reconditioning," 2 units of supervised, postoperative therapeutic exercises for four weeks was supported as reasonable and medically necessary.

In addition, in terms of the ultrasound (#97035) treatments (even if the daily notes had not been computer-generated), it is the position of the Texas Chiropractic Association (reference 1) that it is beneficial to proceed to the rehabilitation phase as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures generally fosters chronicity, physician dependence and overutilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the performance of ultrasound more than 2 months postoperatively was not supported as medically necessary.

And finally, insofar as the treatments rendered from 3/16/04 through 3/22/04 were concerned, they failed to meet the statutory requirements (reference 2), since the patient did not obtain relief, his recovery was not promoted, and there was no enhancement of his ability to return to or retain employment. This is further underlined by the fact that the patient underwent surgery soon thereafter.

**Conclusion/Partial Decision to Certify:**

A maximum of two units per visit of postoperative therapeutic exercises (#97110) from 8/27/04 through 9/24/04 are certified as medically necessary.

All remaining services and procedures – including all units of therapeutic exercises in excess of two units per date of service – are not certified as medically necessary.

**References Used in Support of Decision:**

1. Quality Assurance Guidelines, Texas Chiropractic Association.
2. Texas Labor Code 408.021

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This review was provided by a chiropractor who is licensed in Texas, certified by the National Board of Chiropractic Examiners, is a member of the American Chiropractic Association and has several years of licensing board experience. This reviewer has given numerous presentations with their field of specialty. This reviewer has been in continuous active practice for over twenty years. MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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